KAMALA D. HARRIS
Attorney General of California
ANTOINETTE B. CINCOTTA
Supervising Deputy Attorney General
NICOLE R. TRAMA
Deputy Attorney General
State Bar No. 263607
110 West "A" Street, Suite 1100
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 645-2143
Facsimile: (619) 645-2061
Attorneys for Complainant

BEFORE THE
BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **SPECTRUM PHARMACY;** **TING LI, TREASURER/CHIEF FINANCIAL OFFICER;** **NINA THIEN-NG PHAM, CHIEF EXECUTIVE OFFICER;** **STEVEN DUNG TRUONG, PHARMACIST-IN-CHARGE** **18 Endeavor #100** **Irvine, CA 92618** **Pharmacy Permit No. PHY 48836** **and** **TING LI** **505 City Parkway** **Orange, CA 92868** **Pharmacist License No. RPH 57363** **and** **STEVEN DUNG TRUONG** **18 Endeavor #100** **Irvine, CA 92618** **Pharmacist License No. RPH 52822** **and**	Case No. 5358 **A C C U S A T I O N**

NINA THIEN-NGA TRAN
1236 N. Magnolia Avenue
Anaheim, CA 92801

Pharmacist License No. RPH 55935

Respondents.

Complainant alleges:

PARTIES

1. Virginia Herold (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Pharmacy (Board), Department of Consumer Affairs.

2. On or about October 10, 2008, the Board issued Pharmacy Permit Number PHY 48836 to Spectrum Pharmacy (Respondent Spectrum Pharmacy - Irvine). The Pharmacy Permit was in full force and effect at all times relevant to the charges brought herein and will expire on October 1, 2016, unless renewed.

3. On or about August 16, 2005, the Board issued Pharmacist License No. RPH 57363 to Ting Li (Respondent Li). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2017, unless renewed.

4. On or about September 5, 2011, the Board issued Pharmacist License No. RPH 52822 to Steven Dung Truong (Respondent Truong). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2017, unless renewed.

5. On or about August 4, 2004, the Board issued Pharmacist License No. RPH 55935 to Nina Thien-Nga Tran (Respondent Tran). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein, and will expire on December 31, 2017, unless renewed.

JURISDICTION

6. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

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7. Section 4011 of the Code provides that the Board shall administer and enforce both the Pharmacy Law [Bus. & Prof. Code, § 4000 et seq.] and the Uniform Controlled Substances Act [Health & Safety Code, § 11000 et seq.].

8. Section 4300(a) of the Code provides that every license issued by the Board may be suspended or revoked.

9. Section 4300.1 of the Code states:

> The expiration, cancellation, forfeiture, or suspension of a board-issued license by operation of law or by order or decision of the board or a court of law, the placement of a license on a retired status, or the voluntary surrender of a license by a licensee shall not deprive the board of jurisdiction to commence or proceed with any investigation of, or action or disciplinary proceeding against, the licensee or to render a decision suspending or revoking the license.

10. Section 4307(a) of the Code states:

> (a) Any person who has been denied a license or whose license has been revoked or is under suspension, or who has failed to renew his or her license while it was under suspension, or who has been a manager, administrator, owner, member, officer, director, associate, or partner of any partnership, corporation, firm, or association whose application for a license has been denied or revoked, is under suspension or has been placed on probation, and while acting as the manager, administrator, owner, member, officer, director, associate, or partner had knowledge of or knowingly participated in any conduct for which the license was denied, revoked, suspended, or placed on probation, shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee as follows:
>
> (1) Where a probationary license is issued or where an existing license is placed on probation, this prohibition shall remain in effect for a period not to exceed five years.
>
> (2) Where the license is denied or revoked, the prohibition shall continue until the license is issued or reinstated.

STATUTORY PROVISIONS

11. Section 4022 of the Code states:

> "Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:
>
> (a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a ____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

12. Section 4059, subdivision (a) of the Code states:

A person may not furnish any dangerous drug, except upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7. A person may not furnish any dangerous device, except upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7.

13. Section 4081 of the Code states:

(a) All records of manufacture and of sale, acquisition, or disposition of dangerous drugs or dangerous devices shall be at all times during business hours open to inspection by authorized officers of the law, and shall be preserved for at least three years from the date of making. A current inventory shall be kept by every manufacturer, wholesaler, pharmacy, veterinary food-animal drug retailer, physician, dentist, podiatrist, veterinarian, laboratory, clinic, hospital, institution, or establishment holding a currently valid and unrevoked certificate, license, permit, registration, or exemption under Division 2 (commencing with Section 1200) of the Health and Safety Code or under Part 4 (commencing with Section 16000) of Division 9 of the Welfare and Institutions Code who maintains a stock of dangerous drugs or dangerous devices.

(b) The owner, officer, and partner of any pharmacy, wholesaler, or veterinary food-animal drug retailer shall be jointly responsible, with the pharmacist-in-charge or representative-in-charge, for maintaining the records and inventory described in this section.

14. Section 4113, subdivision (c) of the Code states: "The pharmacist-in-charge shall be responsible for a pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy."

15. Section 4169, subdivision (a)(5) of the Code provides that a person or entity shall not fail to maintain records of the acquisition and disposition of dangerous drugs for at least three years.

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16. Section 4301 of the Code states:

The board shall take action against any holder of a license who is guilty of unprofessional conduct or whose license has been procured by fraud or misrepresentation or issued by mistake. Unprofessional conduct shall include, but is not limited to, any of the following:

. . . .

(c) Gross negligence.

. . . .

(j) The violation of any of the statutes of this state, of any other state, or of the United States regulating controlled substances and dangerous drugs.

. . . .

(o) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate any provision or term of this chapter or of the applicable federal and state laws and regulations governing pharmacy, including regulations established by the board or by any other state or federal regulatory agency.

. . . .

17. Health and Safety Code section 11153 states in pertinent part:

(a) A prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. Except as authorized by this division, the following are not legal prescriptions: (1) an order purporting to be a prescription which is issued not in the usual course of professional treatment or in legitimate and authorized research; or (2) an order for an addict or habitual user of controlled substances, which is issued not in the course of professional treatment or as part of an authorized narcotic treatment program, for the purpose of providing the user with controlled substances, sufficient to keep him or her comfortable by maintaining customary use.

18. Health and Safety Code section 11164 states in pertinent part:

Except as provided in Section 11167, no person shall prescribe a controlled substance, nor shall any person fill, compound, or dispense a prescription for a controlled substance, unless it complies with the requirements of this section.

(a) Each prescription for a controlled substance classified in Schedule II, III, IV, or V, except as authorized by subdivision (b), shall be made on a controlled substance prescription form as specified in Section 11162.1 and shall meet the following requirements:

(1) The prescription shall be signed and dated by the prescriber in ink and shall contain the prescriber s address and telephone number; the name of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services; refill information, such as the number of refills ordered and whether the prescription is a first-time request or a refill; and the name, quantity, strength, and directions for use of the controlled substance prescribed.

(2) The prescription shall also contain the address of the person for whom the controlled substance is prescribed. If the prescriber does not specify this address on the prescription, the pharmacist filling the prescription or an employee acting under the direction of the pharmacist shall write or type the address on the prescription or maintain this information in a readily retrievable form in the pharmacy.

. . . .

REGULATORY PROVISIONS

19. Code of Federal Regulations, title 21, section 1301.11 provides that a person who manufacturers, distributes, dispenses, imports or exports any controlled substances be registered with the Drug Enforcement Administration.

20. Code of Federal Regulations, title 21, section 1306.04 states in pertinent part:

(a) A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. An order purporting to be a prescription issued not in the usual course of professional treatment or in legitimate and authorized research is not a prescription within the meaning and intent of section 309 of the Act (21 U.S.C. 829) and the person knowingly filling such a purported prescription, as well as the person issuing it, shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances.

. . . .

21. Code of Federal Regulations, title 21, section 1306.11 states in pertinent part:

(a) A pharmacist may dispense directly a controlled substance listed in Schedule II that is a prescription drug as determined under section 503 of the

Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353(b)) only pursuant to a written prescription signed by the practitioner, except as provided in paragraph (d) of this section. A paper prescription for a Schedule II controlled substance may be transmitted by the practitioner or the practitioner's agent to a pharmacy via facsimile equipment, provided that the original manually signed prescription is presented to the pharmacist for review prior to the actual dispensing of the controlled substance, except as noted in paragraph (e), (f), or (g) of this section. The original prescription shall be maintained in accordance with §1304.04(h) of this chapter.

. . . .

22. California Code of Regulations, title 16, section 1761 states:

(a) No pharmacist shall compound or dispense any prescription which contains any significant error, omission, irregularity, uncertainty, ambiguity or alteration. Upon receipt of any such prescription, the pharmacist shall contact the prescriber to obtain the information needed to validate the prescription.

(b) Even after conferring with the prescriber, a pharmacist shall not compound or dispense a controlled substance prescription where the pharmacist knows or has objective reason to know that said prescription was not issued for a legitimate medical purpose.

COST RECOVERY

23. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

DRUGS

24. At all times mentioned herein, Hydrocodone/APAP was a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. On October 6, 2014, Hydrocodone/APAP was reclassified as a Schedule II controlled substance.

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25. Diladid is a brand name for hydromorphone, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

26. Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

27. Methadone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

28. MS Contin is a brand name for morphine, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

29. Opana is a brand name for oxymorphone hydrochloride, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

30. Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M), and a dangerous drug pursuant to Business and Professions Code section 4022.

31. Oxycontin is a brand name for oxycodone, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

32. Perocet is a brand name for oxycodone and acetaminophen, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

33. Phenergan with codeine, is a brand name for promethazine with codeine syrup, and is a Schedule V controlled substance pursuant to Health and Safety Code section 11058, and a dangerous drug pursuant to Business and Professions Code section 4022.

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34. Roxicodone is a brand name for oxycodone, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

FACTUAL ALLEGATIONS

35. From October 10, 2008 to March 13, 2013, Respondent Li was the Pharmacist-in-Charge (PIC) of Respondent Spectrum Pharmacy – Irvine and has also been its Treasurer and Chief Financial Officer since October 2008. Respondent Truong worked as a staff pharmacist at Spectrum Pharmacy –Irvine, and he became the PIC on March 13, 2013. Respondent Tran has been the Chief Executive Officer since October 2008, and has worked as a staff pharmacist at Spectrum Pharmacy- Irvine.

36. On or about September 25, 2012, the Drug Enforcement Administration (DEA) with the assistance of the Long Beach Police Department (LBPD) performed an inspection at Respondent Spectrum Pharmacy - Irvine. As a result of the inspection, Respondent Spectrum Pharmacy –Irvine surrendered their DEA registration effective September 25, 2012. During the inspection, a male individual, later identified as "Earl T.," walked into Respondent Spectrum Pharmacy- Irvine. When he noticed the officer and agents, Earl T. began acting suspiciously. The agents and officer noted that Earl T. briefly spoke to pharmacy staff in a quiet voice, and then left the pharmacy. When the officer and agents followed Earl T., he attempted to flee the scene in a vehicle, but was stopped and searched. Earl T. had $6,600 in cash in one pocket and $559 in cash in the other pocket. Earl T. stated that he was from Los Angeles. When asked what he was picking up or dropping off at the pharmacy, Earl T. stated, "nothing." The officer and agents searched the area where Earl T. had exited the building and located eight prescriptions written in sequence by Dr. C.A.,[1] all dated May 7, 2012, for Oxycodone 30 mg, with a different patient's

[1] On December 15, 2014, the Medical Board of California filed a disciplinary action (Accusation) against Dr. C.A. for prescribing controlled substances to addicts, excessive prescribing, dishonest or corrupt acts for engaging in a criminal enterprise though which he was paid to write prescriptions to patients who were not suffering from any medical conditions warranting such prescriptions and for which the patients received remuneration from other individuals for the prescriptions which were then filled and resold for street use, among several other allegations.

name, telephone number, and date of birth on them. The officer and agents also searched Earl T.'s phone and discovered a call to a telephone number identified as "pharmacy steve" [sic] on September 24, 2012. The "pharmacy steve" phone number belonged to Respondent Truong.

37. On October 3, 2012, Respondent Truong was interviewed by LBPD and DEA. Respondent Truong stated that he did not know Earl T.'s last name or occupation, that Earl T. was referred to him by another pharmacist who worked at W&P Pharmacy, that Earl T. would contact Respondent Truong on his cell phone to ask him if he had Oxycodone 30 mg or Phenergan with Codeine in stock, that Earl T. had come into Respondent Spectrum Pharmacy – Irvine several times to fill multiple prescriptions written by the same doctor (Dr. C.A.) for different patients, that Earl T. always paid cash for the prescriptions, and that he never filled a prescription written for Earl T. On Respondent Truong's phone, there was a text message from Earl T. on August 17, 2012 that read, "Dis is earl u have enough for six more cause I want me back until thrusdae r fridae im tryina not to get too backed up." [sic] Respondent Truong admitted during the interview that Earl T. told him that he would pay him an extra $50 if he ordered Oxycodone manufactured by Mallinckrodt.[2] Respondent Truong admitted that he ordered the Oxycodone by Mallinckrodt, but was never paid extra money. Respondent Truong stated that he verified some, but not all, of the prescriptions that Earl T. brought to him, that he never asked Earl T. why he was obtaining these prescriptions, and that he never asks patients why they are getting prescriptions.

38. In October, 2012, in response to a complaint filed with the Board by the LBPD, the Board conducted an inspection of Respondent Spectrum Pharmacy - Irvine. The inspector discovered a prescription, RX 523506, for a controlled substance that had been filled and dispensed by Respondent Spectrum Pharmacy - Irvine on September 27, 2012, two days after its DEA registration was surrendered. When asked, Respondent Truong admitted that he transferred the drug from another pharmacy (Spectrum Pharmacy - Anaheim) to dispense it from Respondent Spectrum Pharmacy – Irvine. Respondent Truong stated that they were no longer transferring

[2] There is a higher street demand for Oxycodone manufactured by Mallinckrodt, as opposed to other manufacturers.

controlled substances, and were instead faxing prescriptions to Spectrum Pharmacy -Anaheim to be filled and dispensed there.

39. During the October 2012 inspection, the inspector also noticed a large number of prescriptions being filled from pain clinics all over Orange County. The inspector noted several prescriptions dispensed by the pharmacy in sequence written by Dr. C.A., whose office was located in Inglewood, approximately 47 miles from Respondent Spectrum Pharmacy - Irvine, for patients from all over Los Angeles. When questioned, Respondent Truong stated that patients sometimes picked up their own medications, but that there was also a driver by the name, "Earle," who would bring in the prescriptions and pick up the medications for patients. Respondent Spectrum Pharmacy- Irvine had no documentation on the identity of Earle. When the inspector attempted to contact Dr. C.A. to confirm that he wrote the prescriptions dispensed by Respondent Spectrum Pharmacy - Irvine, the letter sent to Dr. C.A. by the Board inspector was returned as undeliverable. The inspector also attempted to contact several patients who had been dispensed medications by Respondents, and all of those letters were returned by the United States Postal Service marked not deliverable.

40. As a follow up to the investigation, Respondent Li was asked to answer questions about the patients to whom Respondents had dispensed prescriptions. Respondent Li responded to the inspector's request, and reported that Respondents contact the prescribers to verify new prescriptions, but "do not obtain diagnosis or alternatives 'tried and failed' as that information is not required by California Law." Respondent Li stated that, "It is not the pharmacist's role to discuss other potential medications – that is the role for the physician." Respondent Li provided only limited information about the patients.

41. Upon review of the prescriptions, the Board inspector discovered that Respondents frequently dispensed prescriptions issued in sequence and written several months prior by Dr. C.A., for the same drug and in the same dose (oxycodone 30 mg), with the same directions for use (take 2 tablets three times per day), for different patients located out-of-the-area. For example, on April 25, 2012, four prescription blanks # 4266-4269 were written by Dr. C.A. for oxycodone 30 mg to four different patients, with directions to take 2 tablets three times per day,

and all four of these prescriptions were filled in sequence at Respondent Spectrum- Irvine on July 11, 2012. The following is a summary of those prescriptions:

Date on RX	No. on Prescription Blank	Date Filled	RX No. Assigned by Spectrum	Patient Birth Year	Patient City	Dispensing Pharmacist
4/25/12	4268	7/11/12	521054	1975	Lawndale	Unknown
4/25/12	4267	7/11/12	521056	1966	Los Angeles	Unknown
4/25/12	4269	7/11/12	521055	1970	Gardena	Unknown
4/25/12	4266	7/11/12	521057	1973	Lawndale	Unknown
4/25/12	4271	7/24/12	521452	1981	Los Angeles	ST[3]
4/25/12	4275	7/24/12	521453	1970	Los Angeles	ST
4/25/12	4276	7/24/12	521454	1957	Los Angeles	ST
4/25/12	4272	7/24/12	541455	1975	Los Angeles	ST
4/25/12	4277	7/25/12	521490	1955	Compton	ST
4/25/12	4278	7/25/12	521491	1975	Los Angeles	ST
4/25/12	4279	7/25/12	521492	1959	Compton	ST
4/26/12	4283	7/28/12	521585	1977	Los Angeles	ST
4/26/12	4284	7/28/12	521584	1970	Los Angeles	ST
4/26/12	4282	7/28/12	521586	1969	Los Angeles	ST
4/26/12	4281	7/28/12	521587	1961	Inglewood	ST
4/26/12	4280	7/28/12	521588	1974	Los Angeles	ST
4/27/12	4286	7/30/12	521596	1966	Compton	ST
4/27/12	4287	7/30/12	521597	1951	Los Angeles	ST
4/26/12	4285	7/30/12	521598	1953	Los Angeles	ST
4/27/12	4293	8/1/12	521676	1971	Los Angeles	ST
4/27/12	4296	8/1/12	521677	1966	Compton	ST

[3] The initials ST are Respondent Truong's initials.

1	4/27/12	4295	8/1/12	521678	1954	Los Angeles	ST
2	4/29/12	4294	8/9/12	521910	1979	Los Angeles	ST
3	4/29/12	4292	8/9/12	521911	1974	Los Angeles	ST
4	4/29/12	4291	8/9/12	521912	1956	Inglewood	ST
5	4/29/12	4290	8/9/12	521913	None	Compton	ST
6	4/29/12	4300	8/10/12	521961	1965	Compton	ST
7	4/29/12	4297	8/10/12	521962	1955	Los Angeles	ST
8	4/29/12	4298	8/10/12	521963	1970	Los Angeles	ST
9	4/29/12	4299	8/11/12	521989	1952	Los Angeles	ST
10	4/30/12	4527	8/11/12	521990	1971	Inglewood	ST
11	5/3/12	4538	8/14/12	522046	1966	Inglewood	ST
12	5/3/12	4546	8/14/12	522047	1961	Compton	ST
13	5/3/12	4549	8/14/12	522048	1977	Los Angeles	ST
14	5/3/12	4548	8/14/12	522049	1968	Los Angeles	ST
15	5/3/12	4547	8/14/12	522050	1970	Compton	ST
16	5/2/12	4637	8/16/12	522137	1967	Los Angeles	ST
17	5/2/12	4536	8/16/12	522138	1970	Inglewood	ST
18	5/2/12	4539	8/16/12	522143	1974	Los Angeles	ST
19	5/2/12	4534	8/16/12	522141	1966	Los Angeles	ST
20	5/2/12	4535	8/16/12	522140	1972	Los Angeles	ST
21	5/4/12	4309	8/29/12	522526	1959	Los Angeles	ST
22	5/4/12	4305	8/29/12	522527	None	None	ST
23	5/4/12	4304	8/29/12	522528	None	None	ST
24	5/4/12	4303	8/29/12	522529	None	None	ST
25	5/4/12	4306	8/29/12	522530	1974	Los Angeles	ST
26	5/4/12	4313	8/31/12	522633	None	None	ST
27	5/4/12	4311	8/31/12	522634	1956	Los Angeles	ST
28							

5/4/12	4310	8/31/12	522635	1977	Los Angeles	ST
5/4/12	4312	8/31/12	522636	1972	Los Angeles	ST
5/4/12	4327	9/1/12	522690	None	None	ST
5/4/12	4326	9/1/12	522691	None	None	ST
5/4/12	4318	9/1/12	522692	None	None	ST
5/4/12	4317	9/1/12	522693	None	None	ST
5/4/12	4325	9/1/12	522694	None	None	ST
5/5/12	4314	9/6/12	522774	None	None	ST
5/4/12	4315	9/6/12	522775	None	None	ST
5/4/12	4316	9/6/12	522776	None	None	ST
5/4/12	4321	9/6/12	522777	None	None	ST

42. In addition, Respondents dispensed drugs to multiple patients with fake or non-existent addresses. Respondent Spectrum – Irvine also dispensed 180 tablets of oxycodone 30 mg without a valid prescription. In fact, RX 521585 had no quantity written on the prescription and no checkbox was checked; yet, Respondent Truong dispensed 180 tablets of oxycodone to the patient.

43. Respondents also filled prescriptions for patients who were habitual doctor and pharmacy shoppers, as follows:

Patient R.M.

44. R.M. (DOB 1983) had an address in Inglewood, approximately 45 miles from Respondent Spectrum Pharmacy. From May, 2010 to September, 2012, Respondents dispensed multiple prescriptions to R.M. for oxycodone 30 mg written by five different prescribers, located in Rancho Cucamonga, Panorama City, Los Angeles, and Garden Grove. The use of five different prescribers of the same drug should have been a red flag to Respondents. Some of the prescriptions did not relate to the prescriber's practice. For example, R.M. received a strong pain medication (oxycodone) from Dr. MS, who is a board certified eye specialist. In addition to oxycodone, R.M. was also prescribed other pain medications. R.M. paid cash for all of the

oxycodone prescriptions dispensed by Respondents. Moreover, the prescriptions dispensed by Respondents were not consistent. For example, on July 29, 2010, R.M. received 60 tablets of 60 mg of oxycodone with directions to take the drug twice per day. Therefore, R.M. was taking 120 mg of oxycodone per day. The next month, a different prescriber wrote a prescription for 90 tablets of oxycodone 80 mg, with directions for R.M. to take the drug three times per day. Therefore R.M. received double the dose prescribed the month prior. Respondents should have questioned R.M. and the prescriber about how R.M. was taking their medications, and verify that the prescriber knew about the previous therapies and multiple prescribers to ensure patient safety, and the legitimacy of the prescription.

Patient T.C.H.

45. T.C.H. (DOB 1936) had an address in Riverside, approximately 44 miles from Respondent Spectrum Pharmacy - Irvine. From June 2009 to March 2012, T.C.H. saw seven prescribers from Northridge, Rancho Cucamonga, Culver City, Panorama City, Inglewood, Los Angeles, and Garden Grove, who prescribed her controlled substances, and obtained controlled substances from seven pharmacies in Los Angeles, El Segundo, Torrance, Huntington Beach, Lennox, Irvine, and Alhambra. Respondents dispensed multiple controlled substance prescriptions to T.C.H. from March 2010 to March 2012, and told the inspector that this patient was tested for drugs. The prescriptions were inconsistent. For example, Respondents dispensed to T.C.H. Oxycontin 80 mg, with directions to take it three times per day (240 mg/day) from March to July 2010. In August 2010, Respondents filled a prescription written by a different prescriber for Oxycontin 30 mg, with directions to take it every 4-6 hours (120-180 mg/day). There were no notes or documentation indicating that Respondents spoke with the prescriber or patient about the sudden decrease in dosage. In January 2011, T.C.H. was prescribed Opana (oxymorphone). A few months later, a different prescriber wrote T.C.H. a prescription for oxycodone. Respondent Li stated that T.C.H. tried Motrin for pain, but the pain was significant, and that T.C.H. would pick up her prescriptions after her doctor's appointment in Garden Grove. However, Garden Grove is 15 miles away from Respondent Spectrum – Irvine and, in the

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opposite direction of T.C.H.'s home in Riverside. In addition, T.C.H. also received other pain medications.

Patient F.I.L

46. F.I.L. (DOB 1956) had an address in Inglewood, approximately 46 miles from Respondent Spectrum Pharmacy - Irvine. From March 2010 to September 2012, F.I.L. saw six different prescribers from Rancho Cucamonga, Hawthorne, Panorama City, Los Angeles, and Garden Grove, that prescribed her controlled substance prescriptions, and obtained controlled substances from eight pharmacies in Alhambra, Hawthorne, Irvine, and Santa Ana. The prescriptions were inconsistent. For example, one month F.I.L. was dispensed oxycodone 80 mg with directions to take it three times per day (240 mg/day). The following month, F.I.L. was prescribed oxymorphone. Then the next month, F.I.L. was taking oxycodone again, at a different dosage (120-180 mg). There was no documentation indicating that Respondents clarified the prescriptions, asked about the change in regimen, or spoke to F.I.L. or the prescriber about the medication, the dose, or the other multiple prescribers. Respondents did not answer the inspector when asked whether F.I.L. picked up his own prescriptions from Respondent Spectrum Pharmacy. Respondent Li acknowledged that F.I.L. used multiple doctors.

47. All three of the above patients regularly obtained controlled substances from the same prescribers, including Drs. MA, MS, EC,[4] and Physician Assistant (PA) DN.[5] Had Respondent Spectrum - Irvine utilized CURES reports, they would have been able to determine that the patients were doctor and/or pharmacy shopping or that the patients were receiving narcotic prescriptions from other pharmacies at the same time they were obtaining narcotics from Respondent Spectrum – Irvine.

48. In addition, Respondent Li failed to provide complete records of disposition of controlled substances to the Board inspector. Despite requests by inspectors, Respondent Li

[4] Dr. E.C.'s medical license was surrendered effective November 6, 2015, following the Medical board's filing of an Accusation against him.

[5] PA DN's physician assistant license was disciplined by the Physician's Assistant Committee, effective April 11, 2005, after PA DN committed repeated negligent acts.

never provided complete controlled substance logs showing dispositions of approximately fifty-eight prescriptions from January 1, 2011 to October 5, 2012.

49. Additionally, the Board inspector discovered that Respondent Tran, while working as a staff pharmacist, dispensed Schedule II controlled substance prescriptions from faxed copies and telephonic prescriptions before receiving the original prescriptions as follows:

Patient	Drug	RX No.	Date
RB	Dilaudid Liquid	505877	10/28/2010
IP	Methadone 10mg	517306	3/9/2012
IP	Oxycodone 30mg	517307	3/9/2012
LG	Dilaudid 4 mg	510002	5/23/2011
JH	MS Contin 60 mg	511746	8/10/2011
JH	MS Contin 15 mg	511747	8/10/2011
PW	Fentanyl Patches	511745	8/10/11
DB	Nucynta 75 mg	512400	9/8/2011
DB	Fentanyl Patches	512401	9/8/2011
BC	Percocet 10/325	513103	10/6/2011
TD	Dilaudid 4mg	516887	2/27/2012
OS	Fentanyl patch	516956	2/28/2012

FIRST CAUSE FOR DISCIPLINE

(As to Respondents Spectrum Pharmacy, Li, and Truong)

(Unprofessional Conduct - Failure to Implement Corresponding Responsibility)

50. Respondents Spectrum Pharmacy, Li and Truong are subject to disciplinary action for unprofessional conduct under Code section 4301, subdivisions (j), for violation of Health and Safety Code section 11153, subdivision (a), in that they failed to comply with their corresponding responsibility to ensure that controlled substances are dispensed for a legitimate medical purpose. The circumstances are that they failed to evaluate the totality of the circumstances (information from the patient, physician, CURES and other sources) to determine the prescriptions' were

issued for a legitimate medical purpose in light of information showing that several patients demonstrated drug seeking behaviors such as doctor and pharmacy shopping, numerous patients had addresses outside Respondents' normal trade area, numerous patients saw prescribers that were great distances from the pharmacy's addresses, prescriptions were written for an unusually large quantity of drugs, there were irregularities in the prescriber's qualifications in relation to the type of medications prescribed, several patients came into Respondent Spectrum Pharmacy-Irvine in sequence from the same doctor with prescriptions for the same drug, in the same dose and strength on the same day, and controlled substance prescriptions were provided to an unidentified driver "Earl" without confirming with the patient, among other things, as set forth in paragraphs 35 through 49, which are incorporated herein by this reference.

SECOND CAUSE FOR DISCIPLINE

(As to Respondents Spectrum Pharmacy, Li, and Truong)

(Unprofessional Conduct – Filling Erroneous or Uncertain Prescriptions)

51. Respondents Spectrum Pharmacy, Li and Truong are subject to disciplinary action for unprofessional conduct under Code section 4301, subdivision (o), for violating California Code of Regulations, title 16, section 1761 for filling erroneous or uncertain prescriptions in that Respondents dispensed prescriptions containing errors, irregularities, or uncertainties to patients, as set forth in paragraphs 35 through 49, which are incorporated herein by this reference.

THIRD CAUSE FOR DISCIPLINE

(As to Respondents Spectrum Pharmacy, Li, and Truong)

(Unprofessional Conduct – Gross Negligence)

52. Respondents Spectrum Pharmacy, Li and Truong are subject to disciplinary action for unprofessional conduct under Code section 4301, subdivision (c), in that Respondents were grossly negligent in dispensing controlled substances. The circumstances are that Respondents knew or should have known that the controlled substances dispensed to patients were likely to be used for other than a legitimate medical purpose, and Respondent failed to take appropriate steps when presented with numerous controlled substance prescriptions by patients from the same doctor for the same drug and strength on the same day and who came into Respondent Pharmacy

in sequence. Respondent failed to perform additional investigation to determine whether the prescriptions were issued for a legitimate medical purpose, as set forth in paragraphs 35 through 49, which are incorporated herein by this reference.

FOURTH CAUSE FOR DISCIPLINE

(As to Respondents Spectrum Pharmacy and Li)

(Unprofessional Conduct – Failure to Keep Complete Records)

53. Respondents Spectrum Pharmacy and Li are subject to disciplinary action for unprofessional conduct under Code section 4169(a)(5) in that Respondents failed to maintain records of disposition of dangerous drugs for at least three years as set forth in paragraphs 35 through 49, which are incorporated herein by this reference.

FIFTH CAUSE FOR DISCIPLINE

(As to Respondents Spectrum Pharmacy, Li, and Truong)

(Unprofessional Conduct – Non-Compliant Furnishing a Controlled Substance After Surrender of DEA Registration)

54. Respondents Spectrum Pharmacy and Li are subject to disciplinary action for unprofessional conduct under Code section 4301, subdivision (j), for violating Code of Federal Regulations, title 21, section 1301.11, in that after Respondent Spectrum Pharmacy surrendered their DEA registration, they arranged for a controlled substance be transferred from another pharmacy and to be dispensed from Respondent Spectrum Pharmacy, as set forth in paragraphs 35 through 49, which are incorporated herein by this reference.

SIXTH CAUSE FOR DISCIPLINE

(As to Respondents Spectrum Pharmacy, Li, and Truong)

(Unprofessional Conduct –Furnishing a Controlled Substance Without a Valid Prescription)

55. Respondents Spectrum Pharmacy, Li, and Truong are subject to disciplinary action for unprofessional conduct under Code section 4301, subdivision (j), for violating Business and Professions Code section 4059(a) and Health and Safety Code section 11164, for furnishing a

controlled substance (180 tablets of oxycodone) without a valid prescription, as set forth in paragraph 48, which is incorporated herein by this reference.

SEVENTH CAUSE FOR DISCIPLINE

(As to Respondents Spectrum Pharmacy and Tran)

(Unprofessional Conduct –Non-compliant Dispensing of Controlled Substance Prescriptions)

56. Respondents Spectrum Pharmacy and Tran are subject to disciplinary action for unprofessional conduct under Code section 4301, subdivision (j), for violating Code of Federal Regulations, title 21, section 1306.11, subdivision (a) in that Respondents dispensed Schedule II controlled substance prescriptions from faxed copies and telephonic prescriptions before receiving the original prescription, as set forth in paragraph 49, which is incorporated herein by this reference.

DISCIPLINARY CONSIDERATIONS

57. To determine the degree of discipline, if any, to be imposed on Respondent Truong, Complainant alleges that on or about July 25, 2013, in a prior action, the Board issued Citation Number CI 2011 52553 to Respondent Truong for violation of Business and Professions Code section 4301, subdivisions (f), unprofessional conduct: acts of moral turpitude, dishonesty, fraud deceit or corruption, and subdivision (g), knowingly making or signing any certificate or other document that falsely represents the existence or nonexistence of a fact; and Business and Professions Code section 4342 for drugs lacking quality and strength, and assessed a fine in the amount of $2,500.00. That Citation is now final, and is incorporated herein by this reference.

58. The circumstances that led to the citation are that in January and February 2012, Respondent Truong was the pharmacist-in-charge at Santa Elena Pharmacy. On or about February 10, 2012, during a Board inspection, it was discovered that Santa Elena Pharmacy failed to reverse insurance claims for a patient who did not receive the medication the patient was charged for. In addition, Santa Elena Pharmacy had several medications that were in repackaged bottles and vials with improper labels.

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OTHER MATTERS

59. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 48836 issued to Spectrum Pharmacy, and Ting Li, Steven Dung Truong, and/or Nina Thien-Nga Tran, while acting as the manager, administrator, owner, member, officer, director, associate, or partner of Spectrum Pharmacy, had knowledge of or knowingly participated in any conduct for which Pharmacy Permit Number PHY 48836 issued to Spectrum Pharmacy was revoked, suspended or placed on probation, Ting Li, Steven Dung Truong, and/or Nina Thien-Nga Tran shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 48836 issued to Spectrum Pharmacy is placed on probation or until Pharmacy Permit Number PHY 48836 issued to Spectrum Pharmacy is reinstated if it is revoked.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Pharmacy issue a decision:

1. Revoking or suspending Pharmacy Permit Number PHY 48836 issued to Spectrum Pharmacy;

2. Revoking or suspending Pharmacist License No. RPH 57363 issued to Ting Li;

3. Revoking or suspending Pharmacist License No. RPH 52822 issued to Steven Dung Truong;

4. Revoking or suspending Pharmacist License No. RPH 55935 issued to Nina Thien-Nga Tran;

5. Ordering Spectrum Pharmacy, Ting Li, Steven Dung Truong, and Nina Thien-Nga Tran to pay the Board of Pharmacy the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

6. Prohibiting Respondents Steven Dung Truong, Ting Li and Nina Thien-Nga Tran from serving as a manager, administrator, owner, member, officer, director, associate or partner of a licensee for a period not to exceed five years in the case of probation, or in the case of revocation, until the license is reinstated.

7. Taking such other and further action as deemed necessary and proper.

DATED: 4/16/16

Virginia Herold

VIRGINIA HEROLD
Executive Officer
Board of Pharmacy
Department of Consumer Affairs
State of California
Complainant

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